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High Risk Patient Proactive Collaboration

BACKGROUND

- Delayed notification of a change in status has been associated with poor outcomes (Shearer et al., 2012).
- Proactive rounding by the Rapid Response Team (RRT) of high risk hospitalized patients and collaboration with residents or hospitalists are proposed solutions (Hueckel et al., 2008).
- SJO MET team does not have a streamlined system in place for communicating between a hospitalist and MET RN about patients that are 'high risk' but are not acutely deteriorating.
- 2016 EHR review found that 86% of code blue events outside critical care could have been identified 2-12 hours before the code using high risk criteria for proactive rounding, but MET had only been consulted on 24% of these patients (figures 1 and 2).

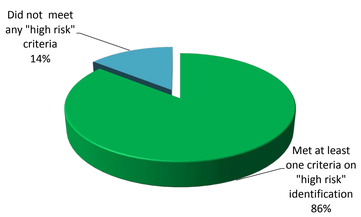

Figure 1 Q2 & Q3 2016

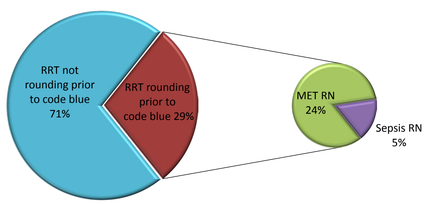

Figure 2 Q2 & Q3 2016

PURPOSE

The purpose of this evidence-based project is to:

- Increase collaboration between floor charge RNs, MET RNs and hospitalists to proactively identify patients at high risk for clinical deterioration.

Aims are to:

- Streamline communication between the RRT and the physician.
- Decrease resuscitations outside of critical care.

METHODS

- Hospitalists are encouraged to notify the MET RN of patients they would like identified as 'high risk' and added to the MET proactive rounding.
- Charge RNs from med/surg units inform MET RN of 'high risk patients' using the High Risk Rounding Tool. This is to be done at bed huddles or during MET rounds on each floor.
- The MET RN contacts the nocturnist covering all of the hospitalists to share the MET rounding list and add any patients of concern.
- The MET RN uses Perfect Serve to update physicians on subtle changes in patients' condition.

High Risk Rounding Tool

Room	Pt Last Name	NEW Confusion, Agitation, or change in LOC	NEW ↑O2 Demands (ie was on 2LNC now on 10 L mask) OR NT suctioning OR Using high amounts of O2 (ie. anyone on NRB mask or Hi flo O2 or high amounts O2 in simple mask or BIPAP)	3 or more of the following CHF, cardiomyopathy with EF < 30%, ESRD, Diabetes, COPD, Active Cancer, PVD, Liver failure or cirrhosis

LIMITATIONS

- Charge RNs are not always aware of the changing status of patients so the report to MET RN may be incomplete.
- The SJH Heritage hospitalist group is the only hospitalist group on Perfect Serve. Some patients do not have a hospitalist and are managed by the specialist.
- It is difficult to standardize a time and place for the MET RN and the nocturnist to meet to discuss patients needing proactive rounding.

References available upon request Jennifer.sturm@stjoe.org

RESULTS AND OUTCOMES

MET	2016	2017	2018 CYTD
Total Number of MET Visits	17886	23548	15385
Proactive Rounding (per 1000 pt days)	6981 (136.4)	8992 (139.5)	7221 (173.2)
Consultative (per 1000 pt days)	1758 (34.4)	2145 (33.2)	1148 (29.8)
Emergent IP (per 1000 pt days)	451 (8.8)	553 (8.6)	572 (15.1)
Emergent ED (per 1000 pt days)	2099 (41.0)	3298 (51.2)	2306 (51.5)
Sepsis-Related Visits (per 1000 pt days)	6597 (128.9)	8470 (131.4)	4165 (104.4)

Code Blue	2016	2017	2018 CYTD
Totals Number of Code Blues	210	272	230
Critical Care Units	161	220	124
Non-Critical Care Units	49	52	52
Critical Care Units/1000 pt days	1.8	2.8	1.9
Non-Critical Care Units/1000 pt days	0.96	0.81	1.3

CONCLUSIONS / DISCUSSION

- Although, data demonstrates an increase in emergent MET calls, implementation of proactively rounding on patients that meet high risk criteria has not shown a consistent decrease in code blue events.
- 2018 Q2-3 EHR reviews show that only 39% of patients had high risk criteria in the hours prior to a code blue, this may represent we are capturing these patients earlier.
- MET RN was proactively rounding on 80% of the patients who had high risk criteria before the code blue.
- MET RN was rounding on 39% of all patients who had Code Blue Events, therefore most patients did not have high risk criteria in the hours prior to the code.
- A literature review is necessary to identify additional interventions to address code blue events.